

Medical Discourse

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Annu. Rev. Anthropol. 2009.38:199-215

First published online as a Review in Advance on
June 19, 2009

The *Annual Review of Anthropology* is online at
anthro.annualreviews.org

This article's doi:
10.1146/annurev-anthro-091908-164450

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0084-6570/09/1021-0199\$20.00

Key Words

authority, interaction, circulation, textuality, conversation analysis

Abstract

Discourse plays an important role in medicine, and medical discourse in the broadest sense (discourse in and about healing, curing, or therapy; expressions of suffering; and relevant language ideologies) has profound anthropological significance. As modes of social action, writing and speaking help constitute medical institutions, curative practices, and relations of authority in and beyond particular healing encounters. This review describes cultural variation in medical discourse and variation across genres and registers. It then surveys two approaches to analyzing medical discourse: conversation analysis (CA) and discourse studies echoing Foucault's work, attempting to spur dialogue between them. Such dialogue could be fruitful because, despite hesitancy to invoke macrosocial variables, conversation analysts as well as Foucaultian discourse analysts have reflected on medical authority. Finally, the article reviews recent attempts to contextualize closely analyzed interactions—written exchanges as well as face-to-face clinical encounters—vis-à-vis the global circulation of linguistic forms and ideologies.

Discourse: instances of language (written and spoken, face-to-face and mass-mediated) in actual use in particular social contexts

CA: conversation analysis

Text: a particular instance of discourse that is coherent, memorable, quotable and thus recontextualizable

INTRODUCTION

This article explores the anthropological significance of medical discourse—a high-stakes topic with clear applied relevance (Cooper et al. 2003, Maynard & Heritage 2005, Roberts et al. 2005) that is also rich ground for developing anthropological theory. Studying discourse (language in its fullness) and medicine together brings us to encounter culture as discursively constituted. As historically situated practices, forms of medical discourse play a role in cultural production and reproduction. Effective intervention in those processes (Hodge et al. 1996) requires insightful assessment of communicative practices in sociocultural contexts (Browner et al. 2003, Kleinman & Benson 2006) (see sidebar, *Gesture and Embodied Communicative Action in Medical Interaction*). This article reviews such practices and contexts.

GESTURE AND EMBODIED COMMUNICATIVE ACTION IN MEDICAL INTERACTION

Speech, gesture, posture, and other acts jointly produce meaning in medical interaction. Patients position themselves to make body parts visible to physicians (Heath 1986; 2002; 2006, p. 207), even while physicians gaze at computerized records (Ruusuvuori 2001). During the physical examination patients constitute themselves as clinical objects, gazing away with apparent disregard while making their subjectivity a clinical resource, e.g., demonstrating pain and its location (Heath 2006). Medical teamwork is coordinated by talk and gesture; one gesture may call for another, as when a junior member of an anesthesia team points to the knob that increases gas flow, eliciting a go-ahead nod from a senior member. Talk can elicit and coordinate physical activity, as when one member tells a patient he will now lay her down flat, prompting another to move to help lay her down (Hindmarsh & Pilnick 2002). Senior surgeons use gestural as well as spoken signs to teach medical school students about the currently problematic body part and guide the ongoing activity. This practice can involve such methods as doing a trace of the body area in the air, precisely located vis-à-vis patient, endoscopic video monitor, and students (Koschman et al. 2007).

Medical discourse inspired two streams of work beginning in the 1960s—one U.S.-based and microanalytic (*The Natural History of an Interview* project; Condon & Ogston 1966, Schefflen 1973), the other macroanalytic (Foucault 1965[1961], 1990[1978]). [The ethnography of communication, emerging at the same time, described local ways of speaking in general, rather than focusing on curing (compare Sherzer 1983).] Face-to-face interaction of patients and physicians remains the focus of what emerged as conversation analysis (CA), mostly within sociology (Heritage & Maynard 2006a,b; Waitzkin 1991). The qualitative analytic approach of CA reflects Garfinkel's (1967) ethnomethodology, viewing social actors like doctors and patients as constituting shared worlds by means of particular actions, especially talk. Quantitatively and qualitatively oriented sociolinguists, whose sociology is more mainstream, have analyzed therapeutic discourse (Labov & Fanshel 1977); translation in multicultural encounters (Aranguri et al. 2006); and the relationship between particular medical concerns motivating the encounter between patient and practitioner and the achievement of attunement to each others' perspectives (Hamilton 2004). Below, I highlight problems in the literature on medical discourse. I then explain why medical discourse is an anthropological concern and survey its variability vis-à-vis culture, genre, and register. In the final, longest section of the article I review contributions to the field, starting with CA (rather than the broader field of sociolinguistics), to highlight debates over medical authority between conversation analysts and contributors to the macroanalytic stream. Finally, I describe recent attempts to link microinteraction to global circulation of texts that help constitute modern persons as well as medicine and its authority.

Insights from the analysis of medical discourse have been applied, for example, to training and certifying new doctors. Roberts & Sarangi (1999) worked collaboratively with the Royal College of General Practitioners to improve forms of doctor-doctor communication. Such collaboration can benefit patients and

doctors, immigrants and nonimmigrants. U.K. doctors whose linguistic experience is with fluent English speakers might expect patients to maintain a factual orientation. Immigrant patients, however, sometimes bring to clinical encounters a troubles-telling orientation (Jefferson & Lee 1992, Wilce 1998). Thus, in multicultural societies, doctors' "training for uncertainty" (Fox 1957) must now include training for managing "interactional uncertainty" (Roberts et al. 2004).

Unfortunately, much of the literature on medical discourse confines itself to practitioner-patient interaction in biomedical settings and tailors proposals for improving communication to biomedical models of the doctor-patient encounter, such as a "patient-centered" or "biopsychosocial" approach [see critiques by Kuipers (1989) and questions by Cooper et al. (2003)]. For Maynard & Heritage (2005), introducing CA in medical education "facilitates the biopsychosocial approach to the interview, as well as a more recent emphasis on relationship-centered care" (p. 434). Anthropologists resist the exclusive focus on biomedicine and practitioner-patient communication and are skeptical about the psychosocial approach as an oft-inappropriate cultural export—into postwar situations, for example—that "merely assign[s] people the role of...patient" rather than recognizing their narratives as potential legal testimony (Summerfield 1995, p. 356). Similarly, talk of "patient empowerment" can be "used...to constrain doctors' responsibility for patients' suffering" (Salmon & Hall 2003, p. 1969). These ideological representations of discourse (as empowering or culturally competent, for example)—or language ideologies—are as important to analyze as clinical interactions.

Communication among practitioners affects health seekers' experiences. This assertion is supported by analyses of many sorts of discursive events involving practitioners interacting with each other: medical school lectures (Linthorst et al. 2007, Martin 1992), grand rounds (Atkinson 1999, Martin 1992), clinical settings where an attending physician consults

specialists (Cicourel 1992) and notes are added to charts (Hobbs 2003), and team meetings of occupational therapists (Mattingly 1998b). To these we might add "development discourse" (Pigg 1996, p. 178) of the sort circulating in schools and public health campaigns in poor countries such as Nepal, in which assertions of biomedical authority are common. These assertions have profound cultural/medical effects that applied anthropologists might be interested in moderating. Programs that train mental health providers in cultural competence involve metadiscourse reflecting on practitioners' and institutions' communicative forms. Such programs aim to improve communication but are often undermined by essentializing premises about cultural citizenship (Giordano 2008), languages, and their speakers (Briggs 2005). One such program erases multilingual competencies of Latino psychiatric patients, representing Spanish (the mother tongue, a phrase reflecting the institutional gendering of the language) as Latinos' only medium for authentic emotional expression and thus for curing problems newly understood as psychological (Santiago-Irizarry 2001). Insightful critiques, such as those offered by Santiago-Irizarry, can potentiate better fixes.

MEDICAL DISCOURSE AS ANTHROPOLOGICAL CONCERN

In this section I present a model of language that best equips us to study medical discourse ethnographically. I situate medical discourse within that model and introduce the sorts of issues that make it a pressing anthropological concern.

Construing the relationship between medicine and discourse broadly in this review makes anthropological sense, although many facets of the relationship may only be mentioned, such as the intersection of music, discourse, and healing (Roseman 1991); disability discourse (Hadder 2007); "laughter as a patient's resource" (Haakana 2001); the iconicity between a sufferer's voice quality and denotative expressions of pain (Wilce 1998, p. 123); and the representation of talk itself as

Language ideologies: metadiscourses and ideas about language(s) and speakers, tied to structures of power, distorting yet influencing the language on which they reflect

a symptom (of mental illness; Ribeiro 1994; Desjarlais 1997; Wilce 2004a,b). Recognizing the vast potential scope of anthropological work on the role of communication in health, illness, and healing follows from understanding the difficulty of cordoning off a domain of medicine from the rest of life. For example, people visit diviners to seek both causes and remedies for various problems, such as a sick child (Nuckolls 1991). But lost cows are also diviner-eligible topics (Wilce 2001). An analytic distinction between medicine and, say, ritual, though analytically useful, should not be confused with reality. Forms of discourse do not mind the boundaries between the domains we conceive or conform completely to institutional norms. Medical discourse itself may have as its “effect . . . the creation and maintenance of the interests of certain hegemonic groups” (MacDonald 2002, p. 464), and ideologies of language per se that surface in discourse on health and illness also appear elsewhere.

Grasping the import of medical discourse in particular requires a general understanding of the functions of language, which in turn helps us avoid essentializing the medical. What any bit of language is apparently about is only the beginning of its signifying activity. Reference and predication—targeting something to which a linguistic expression corresponds (referring), and saying something (predicating) about it—are only the most salient of linguistic functions. Dominant “referentialist” ideologies (Hill 2008), representing language’s prime function as clear, realistic, or sincere reference, rather than performing social acts, help undermine the sociopolitical agency of patients in therapeutic programs (Carr 2006, Desjarlais 1997). Note, however, that referring is social action, for example directing a doctor’s attention toward, or mutually constructing, the object of a clinical encounter (Engeström 1995). Talking about sickness may point to apparently nonmedical topics such as speaker traits (other than illness), relationships, family resources, and the moral order. Stories told by Miskitu lobster divers about courage in the face

of dangers, including decompression sickness, may signal their deserving status to overhearers who control important resources such as boats. Moreover, some of the social and performative meaning of divers’ stories of danger and sickness is carried in their choice of codes (Miskitu, Spanish, Creole, English, etc.; Humphrey 2005).

Attention to whole patterns of signs in discursive events also helps free us from the hold of referentialist language ideologies. Discourse regarded as healing may never refer to sickness or healing or to those present. Javanese wayang (shadow puppet plays), for example, refer to events in old royal courts. It is their circular text structure that works on wayang audiences, repelling “madness, demons, [and] disease” (Becker 1979, p. 233). Navajo stories used in Holyway rituals for eye problems describe Coyote removing his eyes and throwing them in the air or replacing them with balls of pitch (Toelken 1987). Curative efficacy here depends on the iconicity between two acts in Coyote’s time and two steps—performance and healing—in ritual time. The same stories can be used to cause as well as cure sickness, just as in Bangladesh Qur’anic verses may be inserted into amulets to heal or, if written or read backward, to curse. Here again, sign patterning is crucial to event meaning.

Cultural Variation and Globalization

Both commonalities and variation in medical discourse interest anthropologists. Studies of symbolic healing have offered putative universals (Dow 1986) or have located shamanic chants somewhere between “our physical medicine and psychological therapies” (Lévi-Strauss 1963, p. 198). We ought, however, add a layer of reflexivity to such comparisons, asking why they appeal—to Navajos among others (Milne & Howard 2000). Thus our interest in the rich global diversity of discursive and interactional structures present in healing encounters, classifying discourses, reflections on healing signs, and illness talk invites analysis in and of itself, but the interest endures. Consider

the rule among Aboriginal occupants of Darwin fringe camps banning talk about one's past serious illnesses (Sansom 1982). Such stories belong instead to those whose interventions saved one's life. Sansom learned this after asking a man about his racking cough and being told that someone coming soon could explain it; no one else could. If medical discourse is an arena in which selves are constituted as this sort or that, the transferred ownership of "tellability" (Ochs & Capps 2001) in the Darwin fringe camps constantly reinvents a social self, embedded in relations of reciprocity. In Finland and elsewhere, psychoanalysts engage in a temporary ownership transfer, laying claim to middle-class patients' truth (Vehviläinen 2008, p. 138), but with the aim of returning tellability to the analysand, whose healing entails producing a particular narrative of the suffering self (Lévi-Strauss 1963). Shamanic healing marshals multiple sign modalities and sensory experiences—touch, sparks in a rattle (Briggs 1996), and sound (the clanging of a bell meant to awaken a Yolmo body that has lost its soul; Desjarlais 1996). In any context, we should take medical discourse to include local reflections on signs and healing, as in the Yolmo attribution of healing to an aesthetic, rather than symbolic-persuasive, function. Effective healing may require of shamans a beautiful voice quality (Malaysia; Laderman 1987) or a poetics of "wild images" that invite the soul on an invigorating chase (Nepal; Desjarlais 1996). Although recovering lost souls of western analysands may also require a therapeutic aesthetic, and doctors' speech can be as esoteric as shamans', divergent meaning-producing contexts still demand attention.

The stakes of medical discourse go beyond meaning and the reproduction of cultural sensibilities and encompass social reproduction/transformation. Balancing verbal avoidance by some and production of proprietary sickness stories by others is a key form of reciprocity that sustains an Aboriginal community (Sansom 1982). Shamanic curing also reproduces a social order. The particular pattern of alternation between esoteric and everyday linguistic registers in Warao shamans' songs

underscores their authority (Briggs 1996). Still, although it is appropriate to be wary of the romance of resistance (Abu-Lughod 1990), straightforward reproduction of shamans' power is not all that happens in curing sessions. Patients' family members can (cautiously) resist shamanic authority (Brown 1988).

Genre and Register

Beyond cultural particularity, grasping the significance of medical discourse requires exploring particularities of genre, rejecting overgeneral reference to discourses and invocations of narrative that erase the specificity of local genres. Discourse comes already packaged in relation to genres—discourse types or rules that emerge in activity systems such as clinical encounters (Engeström 1995) and are structurally oriented to expectations—so that performances gain conventionalized reception (Bauman 1999).

Specialized discourse genres arose in modern Europe along with sciences such as medicine in histories for which we must account if we are to contextualize medical discourse (Berkenkotter 2008). The emergence of the scientific article (Atkinson 1992); clinical chart note (Berkenkotter 2008, Coker 2003, Luhrmann 2000, Mattingly 1998b); medical textbook (e.g., Kraepelin 1883, Pinel 1801) and atlas (Armstrong 1983); *historiettes* ("little histories") (Goldstein 1987); and case studies fusing fictional-narrative and scientific features (such as Freud's; Berkenkotter 2008) enabled medicine to constitute itself as a science and tool of power. But genres evolve. Expectations governing research articles in the *Edinburgh Medical Journal* changed markedly over three centuries. The individual case reports popular in the eighteenth century yielded, in the twentieth century, to "case-derived statistics . . . as the basis of medical persuasion" (Atkinson 1992, p. 363). An "informational" style, one of conceptual precision and explicit reference to the theory around which articles must now cohere, has displaced an "involved" rhetorical style [using affective language clearly oriented to

Registers: various local speech repertoires understood as indexing roles and statuses, often ranked as "high" and "low"

Genres: types of discourse linked to event types, patterned to fit recipients' expectations of both the discourse and the broader event

interaction, with a letter-like narrative organization; Atkinson (1992, pp. 351–56)].

Nineteenth-century psychiatry sought legitimacy through linguistic reform, which involved coining new mental disease labels such as French *monomanie* (“obsession”), rapidly embraced by the bourgeoisie (Goldstein 1987, p. 153), but also genres as metatexts legitimating the labels. New nosologies structured the semantic field of psychiatric disease entities and retrospectively enabled a particular imagination of the clinical notes in which those entities [e.g., “maniacal-depressive insanity,” coined by Kraepelin (1968)] ostensibly emerged as natural kinds. This is the story of Kraepelin’s diagnostic *Zählkarten* (literally, “counting cards”)—apparently completed post hoc, guided by an a priori vision of the epistemic field (Weber & Engstrom 1997), but still a key inspiration for the series of *Diagnostic and Statistical Manual[s] of Mental Disorders* (APA 2000) first appearing in mid-twentieth century.

Narrative genres are of special importance in many curative traditions, in the production of illness, and in certain approaches to medical anthropology (Garro 2000, Good 1994, Good et al. 1994, Kleinman 1988). Stories sufferers tell construct for them a theory of the world (Capps & Ochs 1995, pp. 21–22). For Good et al. (1994), it is the “subjunctivizing tactics” in sufferers’ narratives that enable such stories to sustain the sick. For example, keeping multiple perspectives in play and introducing “encounters with the mysterious” are strategies that render stories open to various futures. To Radley et al. (2008, p. 1494), illness stories are “constructed retrospectively, looking back from their endings”—as though indeed the end were known and thus might be foreshadowed all along. In yet another twist on the function of narrative, Capps & Ochs (1995) argue that certain features of the stories panic disorder sufferers tell are key to mediating their repeated experiences of panic. Nonsufferers’ narratives often situate events and related feelings within a moral order related to narrators’ capacity to act. Narrating panic involves a more paradoxical form of agency, actively constructing

a form of passivity by assigning to emotions the power to overwhelm the present. Capps & Ochs (1995) thus suggest that therapists explore how to intervene in the narrative construction of panic.

Connections between narrative and agency (including the agency of narrators and narrated figures) have usually been viewed more positively. Mattingly (1998a,b) contrasts narrative and “chart talk” as distinct forms of reasoning in meetings where occupational therapists discuss patients. Chart talk—authoritative, monological, and oriented toward biomedical rationality—elides agency. Therapists’ personal stories allow patients to “emerge” as agents (1998b, p. 274). Patients’ agency may indeed be discussed, albeit reduced to compliance [Kuipers (1989); compare Browner’s (1998) critique of Mattingly’s distinction as oversharper]. The celebration of agency, and of its reassertion in interactions natural to home or clinic as well as in theoretical discourse, may preclude its problematization. The outcomes and social significance of ascriptions of agency by practitioners deserve study in themselves. Recognizing institutional agency in occupational therapists’ stories, as Mattingly does (1998b), is important. Still, we need a rich theory of talk, agency, and self at both super- and subindividual levels (Kockelman 2007). The multivocality of illness narratives (Kirmayer 2000) and the casting of constituent parts of self (viz., feelings) as troublesome agents in panic disorder narratives (Capps & Ochs 1995) imply that stories and tellers have no single, centered agency. The often joint production of illness narratives raises further questions about figuring narrative agency as ownership (Garro 2000, Ochs & Capps 2001, Sansom 1982). Looking beyond individual narrators, the social circulation of illness stories, e.g., AIDS stories, has had enormous consequences (Farmer 1994).

Narrative may be disappearing from clinics (Luhmann 2000, Marinker 2000, Radley et al. 2008, Wilce 2005), persisting (perhaps) as but a minority interest among readers of the *American Journal of Psychiatry* (Berkenkotter 2008). In Bangladesh, eliciting stories from patients is

integral to vernacular healing (Wilce 1998) but marginal to, or disruptive of, efficient psychiatric interviews. The long stories families recounted to an ethnographer with hours to listen disturbed scientific sensibilities: Stories of sorcery causing madness and of lawsuits against sorcerers (Wilce 2004a). When families take deviant members to psychiatrists, their stories stay home, although, in at least a few cases, families' stories can still come to reflect something of the psychiatrist's rationalized, disenchanting discourse.

Genres are distinct from discursive registers—repertoires of linguistic forms understood locally as different ways of saying the same thing. Registers index such things as speaker role or status (Agha 2007). A shamanic register (Briggs 1996) is not how shamans speak at all times but is instead a toolkit with which they do something, sometimes. We perform work-related social identities using one register and other identities with other registers elsewhere. Medical registers of German (Weber & Engstrom 1997), French (Goldstein 1987), English (Atkinson 1992, Berkenkotter 2008), or other languages (Lee 1999, Liebeskind 2002, Wilce 2008) may be performed in many genres—textbooks or chart notes, for example. Performing medical interviews (another genre) might mean alternating between an esoteric medical register and an everyday register in which patients are more comfortable, mirroring the alternation of registers in Warao shamanic discourse (Briggs 1996). The process by which registers emerge and become recognizable—"enregisterment" (Agha 2007)—attracts increasing attention, and we return to it below.

CONTRIBUTIONS TO THE STUDY OF MEDICAL DISCOURSE

The last section of this article surveys attempts to address issues such as medical authority (from a CA perspective) or power (particularly medicine's incitement to discourse) and the ways in which local medical interactions reflect the global circulation of discourse forms.

Authority in Conversation

CA has provided at least some of the inspiration for many close analyses of medical discourse (Mishler 1984). CA highlights emergent co-construction of meaning, denying for instance that doctors unilaterally impose diagnoses or therapies (Engeström 1999, Maynard & Frankel 2003). Like all interlocutors, doctors and patients are accountable to each other, i.e., they have an "obligation to index the grounds on which their conclusions are formed" (Heritage 2005, p. 92). News deliveries follow the same rules in the clinic as in conversation (Gillotti et al. 2002, Peräkylä 1998, Wittenberg-Lyles et al. 2008), particularly a preference for foreshadowing revelations. Bluntness, however, is another strategy medical personnel may follow in certain circumstances, not to assert power but for immediate interactional reasons, e.g., to break through resistance (Maynard 2003).

A rare example of raw power may be the case of company doctors urging workers complaining of illness back to their jobs, downplaying the seriousness of complaints (Mishler 1984, Waitzkin 1991). More universal is the healer's power to "name the world" (Heritage 2005, p. 99). Yet clients also have some authority (regarding their own experience) and influence. Parents sometimes demand antibiotics for their children (Stivers 2002), leading doctors to push back—or negotiate (Stivers 2005). Physicians in other circumstances may secure patient agreement by offerings grounds, early on, for diagnoses announced later (Mangione-Smith et al. 2003). Eliciting patients' perspectives at an appropriate juncture (Gill & Maynard 2006) may not compromise health workers' authority, but rather prevent miscommunication that contributes, for example, to relatively high rates of amniocentesis refusal by Mexican-origin clients in genetic counseling (Browner et al. 2003; on discursive strategies for dealing with genetic risk, see Sarangi et al. 2003; on apparently positive instances of misunderstanding, see Sachs 1989). Such "tacit bargaining" (Heritage 2005, p. 99), in which exercises of authority

Enregisterment: the process by which a linguistic register emerges and solidifies as a recognized, ideologically construed set of forms

are balanced by “social accountability”—i.e., providing grounds (Peräkylä 1998, 2002; Robinson 2003)—apparently indicates limits on practitioners’ authority (on the similar dialogism that emerges in Bangladeshi divination encounters concerning children’s health, despite the appearance of ex cathedra authority, see Wilce 2001). Still, if Gill & Maynard (2006) are correct, the “organization of the medical interview” (Cohen-Cole 1991) works—together with tacit agreement by patients and doctors that the information-gathering phase, when patients’ perspectives would (ironically) be most relevant, should not be disrupted—to sustain doctors’ (or biomedicine’s) epistemic authority.

CA-inspired work in the 1980s and 1990s used frequency of interruptions or unilateral topic changes as a token of practitioners’ power (Ainsworth-Vaughan 1998, Waitzkin 1991, Wilce 1998; on the difficulty of operationalizing interruptions, see Murray 1985). In one study of gender in clinical interactions, patients succeeded in initiating topic changes only if doctors went along. Doctors’ topic changes apparently required no agreement. Male doctors made three times more unilateral topic changes than did female doctors (Ainsworth-Vaughan 1998; compare Todd 1993, Cordella 1999, Uskul & Ahmad 2003). Similarly, doctors may fail to attend to voiced-and-embodied demonstrations of patients’ suffering, with consequences for patient health but apparently none for the clinical relationship, whereas patients who ignore doctors threaten that relationship (Heath 1986, p. 98). A more complete understanding of medical authority requires attending to discourse histories beyond a single clinical encounter—whole strings of discursive encounters (Atkinson 1999, Cicourel 1992, Erickson 1999), including discourse involving only care receivers, or familial talk (for a tracking of health complaints from home to practitioners of various kinds, and back again in rural Bangladesh, see Wilce 1998). The next subsection focuses on such histories.

Confessional Production of Modern Subjects

As one who illumined those discourse histories, Foucault (1990 [1978]) posited the productive-power role of medical or therapeutic encounters in constituting modern persons as “subjects in both senses of the word” (p. 60). Medicalization, affecting ever more domains of life, has increasingly commanded anthropologists’ attention. The related process of psychologization (Rieff 1987[1966]), rendering ever broader swaths of life therapy-relevant, likewise involves power-laden ideologies of communication, as when using language to express feelings is represented as a value in and of itself. Foucault describes the Catholic mandate to confess sins spreading to medicine, “recodified as [a] therapeutic operation” (1990, p. 67), so that the modern subject “has become a confessing animal” (p. 59). Recent studies (Carr 2006, Smith 2005) have rigorously analyzed the discursive practices and ideologies constituting this Foucaultian regime. Practices that create a putatively therapeutic environment in a drug treatment program for women, for example, involve “incitement to discourse” (Foucault 1990, p. 56). Staff pushes participants toward the discursive style embodied in the motto “Honesty, Openness, and Willingness” (HOW). HOW is an instrument of power. Its insistence that language is a tool for at least potentially truthful reference to inner states (feelings) occludes institutional forces rewarding some discursive acts and punishing others. This referentialist ideology of language works “to minimize the potential of words to point, protest, or critique” (Carr 2006, p. 635).

The dominant ideology in the field of psychotherapy represents client-speakers as entities existing independently of discourse. But Foucault’s point was that, by inciting to discourse, therapeutic encounters actively produce subjects oriented to such discourse. Carl Rogers’ therapeutic practice, for example, projected an authentic self realizable in therapy (Smith 2005, p. 259). The confessional nature of Rogers’ approach, encouraging

clients to verbalize epistemic commitments to embodied experience—e.g., to feeling, but also saying, that her cheeks are hot—is a study in contradiction. Psychoanalysts often speak for analysands (Vehviläinen 2008), in putative contrast to Rogers’ nondirective means of guiding clients to insight. In fact, however, Rogers actively modeled statements of insight, revoicing clients’ utterances to make them refer to the embodied present. Rogerian discourse on authenticity may have had an “impact . . . on folk concepts of selfhood” (Smith 2005, p. 270) in post-World War II America. Even biomedical encounters now feature an “incitement to speak”—and speak emotionally—“increasingly construct[ing] the patient, through various discursive practices, as an experiencing, [feeling,] communicating subject” (Peräkylä 1995, pp. 339–40; compare Arney & Bergen 1984).

Local Interaction, Global Circulation

Because sociocultural processes increasingly unfold at intersections of locality and globality, i.e., because of their “glocality” (Brenner 1998), that is where we increasingly find urgently relevant examples of medical discourse. How the ideologies and discursive practices I have just described circulate globally concerns us in this final subsection. We must find ways to track such discourse forms and ideologies circulating in and through local face-to-face encounters. For example, the globally hegemonic ideology of “communicability” (Briggs 2005) reinforces inequalities through its peculiar imaginings of health and communication. Briggs & Mantini-Briggs (2003) provide a shocking account of this deadly ideology traveling to, within, and beyond Venezuela during a cholera epidemic. The ideology of communicability involves nation-states and experts representing some (racialized) groups as agents in medical knowledge production, others as “translators and disseminators, others . . . receivers, and some simply out of the game” (Briggs 2005, p. 274). Evidence of that grand-scale process

also emerges in a CA-driven study in Los Angeles County, where the race and education level of parents determine how directly some doctors interact with child-patients (Stivers & Majid 2007).

When Langford (2002) visits an Ayurvedic doctor in India to discuss her condition, the popular practitioner also reports having found the true essence of Ayurveda—in treating foreigners. South Asia is the site of newly imported genres of medical discourse, e.g., the psychiatric/psychological advice column (Halliburton 2005, Wilce 2008). Psychiatric discourse in magazines and newspapers has not displaced possession and exorcism in south India. Yet, whereas decades ago in Kerala troublesome spirits had distinct names and personalities, today they introduce themselves with generic names, much like the spirits exorcised by charismatic Catholics in the United States (Csordas 1997). Similarly, Cherokee medical texts underwent a transformation from the late-nineteenth to the mid-twentieth century, involving a loosening of the texts’ indexicality, their contextual groundedness. Before the forced migration of the Cherokee people, medicinal texts evoked and activated the healing relevance of “the geocosmological surround” (Bender, n.d., p. 17)—crucially, the cardinal directions and the colors associated with them. Texts dating after the removal, by contrast, invoked signs such as colors and “spirits for their general symbolism rather than their attachments to place and indexical centering potential” (p. 36). Such combinations of continuity and change exemplify medical discourse’s glocality.

Translation/interpretation. The exploding global circulation of people, goods, and ideas that defines late modernity necessitates armies of medical interpreters or translators. Too many in those armies are unpaid conscripts—patients’ family members, including nonadult children (Cohen et al. 1999); hospital staff untrained as interpreters (Elderkin-Thompson et al. 2001); even strangers in waiting rooms

Indexical: a word, gesture, etc. having as its meaning the particular way that it invokes or creates contextual features (spatial, temporal, or social)

Interactional

textuality: social acts performed in a particular interaction that make it cohere as a sociocommunicative event with a representable outcome

Denotational

textuality: what is said in an event of coherent discourse about something, and the structure of its denotative elements

DSM: the Diagnostic and Statistical Manual of Mental Disorders

SJSR: *shenjing shuairuo*, the Chinese illness label glossed as neurasthenia

Bangla: the local name, and increasingly the preferred scholarly name, for the language often called Bengali

(Flores 2006). Interpreters do not convey everything patients say, resulting in distortion (Aranguri et al. 2006). Patients' children are especially likely to avoid sensitive issues (Flores 2006). The ad hoc approach to medical interpretation in the United States reflects the devaluation of subordinate languages and their speakers, i.e., racialized classes of people who become associated with "ignorance" (Briggs 2005)—a paradox, given the institutional reproduction of ignorance of linguistic diversity that renders medical communication difficult.

Interpreters and their particular communicative styles affect clinical outcomes (Preloran et al. 2005). But translation in and beyond the clinic involves more than clear transfer of information across difference; it involves power (Giordano 2008). A Xhosa translation of the Beck Depression Inventory (Beck 1976) was produced in South Africa during apartheid. Taking steps to ensure the translation's "accuracy," including back translation and having "bilinguals take the same test in two languages" (Drennan et al. 1991, p. 367), failed to address "the power differential" (p. 361). The translation team's own discourse reflected the kind of essentializing relativism that buttressed apartheid, including the "folk-Whorfian" (Silverstein 2000) notion that populations either have or lack "a word for [X, e.g., sadness]" and that absences reflect primitiveness. Such discourse structured the team's attempts to grapple with difference and sameness (Drennan et al. 1991, pp. 371–73) and its reproduction of social inequality (compare Yen & Wilbraham 2003).

Textuality. Translated or not, why do some forms of discourse circulate widely while others do not? Discourse is variably coherent, memorable, quotable, and thus "textual." From any instance of speech-in-interaction two kinds of "textuality," or structures of coherence, can emerge: interactional textuality, i.e., the social acts, statuses, and shifts performed in talk (including outcomes like being insulted); and

denotational textuality (Silverstein 2004), the quotable "said"-ness of discourse and forms of patternment involving denotative meanings. Elaborate denotational patternment typifies ritual communication (Silverstein 2004), but even a conversation about one topic hangs together denotatively. The entextualization (memorable patterning) of discourse enables its circulation.

The denotational textuality of the DSM, psychiatry's bible [the American Psychiatric Association's *Diagnostic and Statistical Manual* (APA 2000)], facilitates its global circulation as authoritative discourse. For Gaines (1992, p. 14) its way of dividing illnesses into a very few macrocategories reflects dualisms of mind and body, emotion and thought. This is the DSM's coherence. Psychiatric conferences reproduce DSM categories, as sessions on particular diagnoses legitimize illnesses and their textual matrices; the DSM typically defines what is arguable in such sessions. What happens when anthropologists' writings juxtaposing local versus DSM categories circulate globally? A version of Kleinman's (1986) ethnographic account of *shenjing shuairuo* (SJSR, "neurasthenia") as a diagnostic category in China has entered psychiatric discussions there, motivating the replacement of SJSR with *yiyu zheng* ("depression") (Lee 1999). Kleinman's descriptions of the complex functions of SJSR are rich and politically sensitive but, in their circulation in China, are stripped of ethnographic contextualization. Drug companies now push *yiyu zheng* to Chinese doctors as a more scientific construct than SJSR. Discursive forms—"hard-sell lectures" and presentational "razzmatazz"—have been central to the successful campaign (Lee 1999, pp. 362, 365).

"Psy disciplines" like psychiatry and psychology have "disseminated themselves rapidly" through genres such as the magazine advice column (Rose 1996, p. 34). A Bangladeshi advice column is contributing to the enregisterment of a psychiatric Bangla (the sedimenting of a psychiatric register). The psychiatrist-editors answering readers'

letters introduce English DSM disease labels such as “social phobia.” Recurrent discourse frames lend the new terms authority. These include an apparently meaningful echo of the English “you are suffering from . . .,” recognizable as authoritative medicalese since the nineteenth century (Wilce 2008, p. 94). The elaborate entextualization that typifies ritual communication ironically appears in the column, as psychiatrists combating the use of charms and Islamic medicine embed DSM labels in a poetics of modernity. Such poetic structuring of at least some of their letter responses and face-to-face encounters with patients and their families—a layering of contrasts (modern/traditional, urban/rural, knowledge/ignorance, etc.)—may add rhetorical punch (Wilce 2008).

Interactional textuality and healing. In cultural context, forms of interactional textuality such as the achievement of coordination in turn taking, or alignment toward a shared sense of the activity at hand, can take on affective meanings such as intimacy. Senegalese patients ground the efficacy of encounters with *sériñs* (vernacular healers, *marabouts*) in that intimacy, coupled with hierarchy. The *sériñs*’ reciting of Islamic texts in Arabic reproduces hierarchy, whereas initial greeting exchanges marked by intensive latching (turn exchanges with no perceptible intervening pause) create intimacy. “The relative lack of temporal separation between the turns comes to signify a relative lack of interpersonal separation between the speech participants” (Perrino 2002, p. 234). A Senegalese commentator compared the tight coordination of turns to musical harmony and braided hair (Perrino 2002, p. 239). Like denotational textuality, such patterning—albeit interactional and thus more grounded in nonrepeatable context—is memorable, characterizable, and thus repeatable, i.e., circulates across time and space. Its significance becomes clearer in the breach. We have long suspected that attempts by multinational agencies to

encourage traditional medicine (TM) through partnerships with biomedicine end up transforming TM (Perrino 2007, p. 1). Perrino’s comparative analysis of patients’ experiences with *sériñs* versus *tradipraticiens* at an NGO-funded TM hospital in Senegal shows through careful discourse analysis the loss of the unique traditional form of interactional textuality experienced by patients as healing in itself. No Arabic words are uttered, no Islamic texts are invoked, and a distancing bureaucratic register replaces the conversational performance of intimacy.

CONCLUSION

Studies of medical discourse have contributed to broader anthropological projects including the analysis of ideologies that empower some communicators and stigmatize others as pre-modern (Briggs 2005). Rooted in close analysis of dyadic clinical encounters and other forms of medical discourse, recent studies trace interactions between globally circulating discourse forms and local traditions that have constituted medical relationships, broadly construed. Textuality, be it denotational (like the DSM’s) or interactional, enables discourse to circulate, but competing patterns meet on an unlevel playing field. Further studies focusing on encounters of different forms of textuality, as in Senegal, are called for, as are others investigating how generalizable is the paradoxical affinity of scientific and ritual discourse apparent in the elaborate entextualization of some Bangladeshi psychiatrists’ discourse. Finally, given that some studies consistently uncover patient-practitioner collaboration and a degree of agency on the part of patients, whereas others find in somewhat similar settings a straightforward reproduction of power relations, both empirical and theoretical work to illuminate this contradiction are needed. Such studies stand to contribute to critical medical anthropology and to help those seeking not only to describe but to change medical worlds.

SUMMARY POINTS

1. The anthropological significance of medical discourse becomes clear through acquaintance with its scope of variation, its potential for generating particular kinds of subjects, the complexities involved in the reproduction of power and inequality at sites of such discourse, and the ways language and discourse work in general.
2. Medicine as practiced in some sites is becoming increasingly like psychotherapy in requiring patients to speak, and speak emotionally, whereas such speech genres as narrative may be disappearing from other areas of medicine.
3. Instances of medical discourse typically circulate to the extent that they are coherently structured, i.e., that their linguistic expressions and denotative meanings are memorably patterned.
4. The genres and registers typifying medical discourse have histories that we can, and should continue to, trace as they spread to new areas and become part of public culture.
5. The prerequisite for developing effective interventions aimed at improving communication in medical settings is an adequate understanding of site-particular communicative practices—including the linguistic genres and registers in use and ideologies of communication that shape these practices.

DISCLOSURE STATEMENT

The author is not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

ACKNOWLEDGMENTS

Joel Kuipers's work has inspired my thinking on these matters (Kuipers 1989) and influenced the structure of my review. For reading and commenting on whole or partial drafts, thanks go to Robert Desjarlais, Anssi Peräkylä, Carole Browner, Seamus Decker, Aaron Denham, Sabina Perrino, Arthur Kleinman, Sing Lee, and Elinor Ochs.

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